OFFICE OF THE INSPECTOR GENERAL FOR MENTAL HEALTH, MENTAL RETARDATION AND SUBSTANCE ABUSE SERVICES

Primary Inspection
Central State Hospital

James W. Stewart, III
Inspector General

Report #114-05

CENTRAL STATE HOSPITAL
PETERSBURG, VIRGINIA
March 1-3, 2005
OIG Report #114-05

INTRODUCTION: The Office of the Inspector General (OIG) conducted a primary inspection at Central State Hospital in Petersburg, Virginia during March 1-3, 2005. The inspection focused on a review of the facility through the application of 19 quality statements. These statements are grouped into 6 domains that include facility management, access to services, service provision, discharge, quality of the environment, and quality and accountability. The quality statements were formulated through interviews completed by the OIG with a number of stakeholder groups. These groups included the mental health facility directors, consumers, Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) Central Office administrative staff, DMHMRSAS Office of Mental Health Services staff and directors of mental health services for community services boards (CSB). The quality statements and the information obtained by the OIG through observations, interviews and a review of documents are described in this report. The report is divided into sections that focus on each of the domains previously noted.

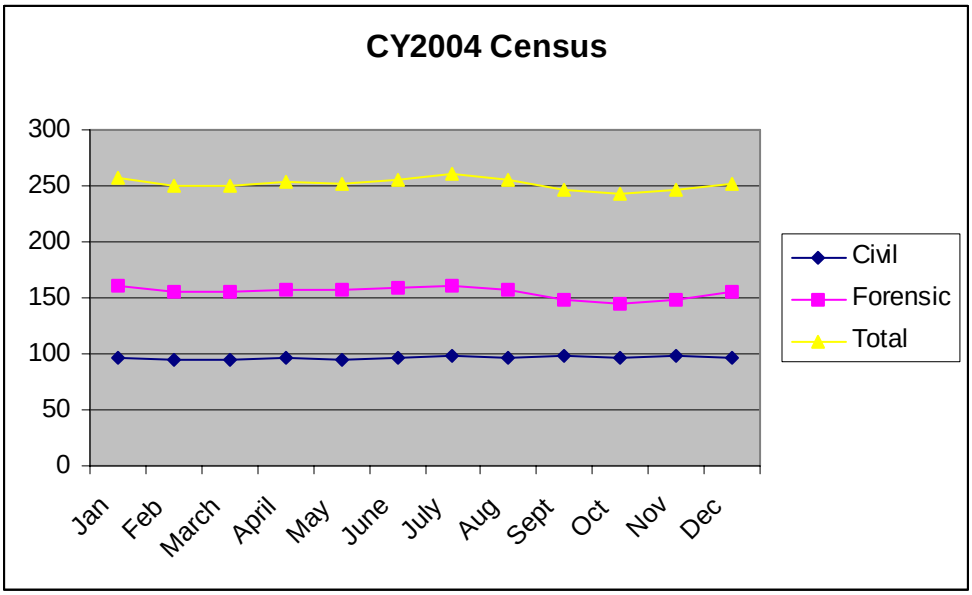
SOURCES OF INFORMATION: Interviews were conducted with 36 members of the staff including administrative, clinical and direct care staff. Interviews were also completed with 14 consumers. Documentation reviewed included, but was not limited to, 6 consumer records, selected policies and procedures, staff training curricula, the facility quality management plan, and risk management reviews. A tour of the facility was conducted. Graphs in this report were created from data provided by the facility.

BACKGROUND: CSH is one of seven mental health facilities and the only maximum security forensic services facility operated by DMHMRSAS for adults between the ages of 18 and 64. It is also one of the five facilities that were reviewed by the Department of Justice (DOJ) in the 1990s.

CSH is the primary hospital for seven CSBs, including Chesterfield, Crossroads, Planning District 19, Goochland-Powhatan, Hanover, Henrico, and the Richmond Behavioral Health Authority. The approved budget for this facility in FY 2004 was approximately $42.4 million, all of which was expended. The facility's budget for FY 2005 is $44.3 million. This represents an increase in funding from the previous fiscal year of $1.9 million.

The average cost per bed day for the total hospital, according to facility data, is $559.67, but it was noted that the costs vary for each of the cost centers and buildings. The per bed day cost for each building is as follows: Civil Units – Building 94 ($494.31), Building 95 ($493.33) and Forensic Units – Building 39 maximum security ($760.50), Building 96 ($490.30). The cost of maximum security is $268 higher than the average cost of the other 3 buildings.

The facility's operating capacity was reported to be 277 beds, of which 100 (36%) are dedicated to civil services and 177 (64%) to forensic services. At the time of the inspection, the facility had a census of 239 consumers in-house with 9 additional consumers on pass from the facility. The census on the 1st day of each month during 2004 was as follows:



MENTAL HEALTH FACILITY QUALITY STATEMENTS

Facility Management

1. The facility has a mission statement and identified organizational values that are understood by staff.

Following is the written mission of the facility:

> *It is the mission of Central State Hospital to provide state of the art mental health care and treatment to forensic and civilly committed patients in need of a structured, secure environment. The major components of the hospital's mission include:*
>
> - *Evaluation: To provide professional evaluations including recommendations to the courts and other agencies*
> - *Treatment: To design and provide individualized quality treatment for mentally ill patients utilizing a biopsychosocial rehabilitation model*
> - *Protection: To maintain a secure, safe, therapeutic and supportive environment for the benefit of the patients, staff, and the community*
> - *Disposition: To prepare our patients for transfer or discharge to the next level of care.*

The facility's values as outlined in information provided to the OIG included the following:

> *CSH is committed to clinical and organizational excellence and a strong spirit of community while providing patient care within an atmosphere of dignity and respect. Patients and employees are empowered and held accountable to identify problems, propose recommendations and implement solutions. Values of great importance are:*
>
> - *Excellence*
> - *Security*
> - *Safety*
> - *Spirit of Community*
> - *Dignity and Respect*
> - *Innovation*
> - *Individual Responsibility*
> - *Diversity*

Direct service and supervisory staff were not able to provide a clear and consistent description of the facility's mission or the organizational values. The most frequent description provided regarding the mission was simply to provide services. Security was mentioned most often as the organizational value.

2. The facility has a strategic plan.

Administrative staff reported that strategic plans have not been updated in the past three years. This was in part attributed to several changes in leadership during the same period. Interviews revealed that since the new facility director was selected, the leadership team has identified a number of priorities and has been working on them. The leadership team plans to review and update, as appropriate, the facility's strategic plan prior to July 1, 2005.

The current strategic plan has seven primary goals that include: 1.) To meet the needs/improve the adaptation of our patients, 2.) To ensure the safety and security of our patients and staff, 3.) To comply with standards, 4.) To improve employee satisfaction, 5.) To increase the freedom of our patients and ensure a least restrictive environment, 6.) To improve the image of CSH, and 7.) To improve hospital efficiency and effectiveness.

3. The mission and strategic plan have been reviewed and are linked to the recently adopted DMHMRSAS Vision Statement.

Administrative staff reported that the facility's mission and strategic plan have not been reviewed in the context of the recently adopted DMHMRSAS Vision Statement. The facility has plans to establish a quality improvement team in late March 2005 that will review the mission and values of the facility.

4. There are systems in place to monitor the effectiveness and efficiency of the facility.

Improving hospital effectiveness and efficiency is one of the goals in the current facility strategic plan. Five strategies for accomplishing this goal have been established. Administrative staff reported that quality processes and corresponding outcome measures are being reviewed for the purpose of addressing and monitoring each of the strategies. The strategies include:

- Improve the budget management process to increase accountability
- Evaluate and improve the facility's staffing plan and align the plan with the mission
- Reduce the use of staff overtime
- Improve competency assessment and training of staff
- Improve the facility's ability to analyze seclusion and restraint data.

Efficiency and effectiveness are also measured within each professional discipline. Among the professional disciplines that have quality review processes are the medical, nursing, social work, psychology, and rehabilitation staff. Some of the methods included documentation checks, peer reviews of assessments and recommendations, drug use studies, and the use of practice guidelines. An additional measure used with forensic patients is the successful and timely completion of a court-ordered evaluations or conditional releases.

5. There are systems in place to assure that there is a sufficient number of qualified staff.

Facility management reported that CSH has 836 approved full-time employee positions. At the time of the inspection, the equivalent of 673 positions or 80% of the approved positions were filled. Of the filled positions, 440 (65%) were assigned to direct care: 68 registered nurses (RN), 27 psychiatric practical nurses (PPN), and 342 forensic mental health technicians (FMHT). A significant percentage of the approved nursing positions were vacant: 30% of RN's and 47% of PPN's. The availability of RN's to provide direct care was complicated by the fact that 29 or 42.7% of the filled positions were assigned to supervisory duties. At the time of the inspection, the facility was utilizing 34 RN positions from contract agencies to supplement nursing coverage.

Direct Care Staffing

	Approved Positions	Filled	Vacant (% of approved)	Supervisory (% of filled)	Contract (% of filled)
RN	98	68	30 (30%)	29 (42.7%)	34 (50%)
PPN	51	27	24 (47%)	NA	NA
FMHT	384	342	42 (11%)	NA	NA
Total	533	440	96 (18%)	NA	NA

CSH staffing includes the following numbers of filled clinical positions:

Medical Staff

- The facility has a medical director, 13 psychiatrists, 4 medical doctors, and 2 nurse practitioners. The medical director also supervises the staff of the forensic evaluation team, which is directed by a psychologist.

Psychology

- The Director of Psychology oversees the work of two divisions. The Treatment Team division consists of 3 psychology supervisors, 15 psychologists and 5 psychology assistants. The Behavioral/MR division includes a psychology supervisor, 2 psychologists, 4 RNs, 1 Occupational Therapist (OT), 1 vocational rehab specialist and 3 human services careworker specialists.

Social Work

- Social Work Department staff include a Director of Social Work, 2 social work supervisors, 9 Master's level clinical social workers, 4 Bachelor's level social workers and 3 human services caseworker specialists. In addition, the facility has an aftercare team, which consists of a social work supervisor, 1 clinical social worker, I RN and the Utilization Review coordinator.

Rehabilitation

- Rehabilitation Department staff include a Rehabilitation Services Director, 2 program service supervisors, 3 OT supervisors, 1 OT, 1 OT assistant, 1 recreational therapy (RT) supervisor, 6 RT's, 3 music therapists, a vocational rehabilitation evaluator, a vocational employment counselor, a chaplain, 2 barber/hairdressers, and 20 human services careworker specialists.

Registered nurses have been the most difficult positions to fill. The facility relies heavily on contract nurses to supplement RN staffing. It was reported that the average salary for recently employed direct care staff is $21,657 and for registered nurses is $44,737. The average annual cost of contract nurses for a standard work schedule of 2080 hours per year is $89,336. The total spent on contract RN's for the 12 month period from April 2004 through March 2005 was $3,321,896.

Administrative staff explained that one of the reasons recruiting is difficult is the perceived reputation of the facility by the community. It was suggested that the perception is that staff are frequently injured while carrying out their duties. The facility's strategic plan outlines several strategies for improving the image of the facility within the community. In addition, the facility has recently hired a recruitment specialist and engaged in a pilot project with Monster.com to enhance recruitment and retention efforts.

Staffing and unit census as observed by the OIG for RN, PPN, and FMHT positions during the inspection were as follows:

EVENING SHIFT (MARCH 1, 2005)

	STAFFING	CENSUS
Building 39		
Forensic Long Term Unit		
	1 RN, 3 FMHTs	20 consumers
Forensic Admission Unit #5		
	1 RN, 1 PPN, 2 FMHTs	12 consumers

One consumer from this unit was on special hospitalization status.

Building 94		
Ward 94-1		
	1 RN, 1PPN, 4 FMHTs	19 consumers

Two consumers were on a temporary pass. One was on special hospitalization status. One was absent without leave.

Ward 94-4		
	2 RNs, 4 FMHTs	21 consumers

DAY SHIFT (MARCH 2, 2005)

Building 96		
Ward 96-1		
	2 RNs, 4 FMHTs	17 consumers
Ward 96-3		
	1 RN, 1 PPN, 3 FMHT	21 consumers
Ward 96-4		
	1 RN, 1 PPN, 3 FMHT	19 consumers

EVENING SHIFT (MARCH 2, 2005)

Building 95		
Ward 95-1		
	1 RN, 1PPN, 3 FMHT	23 consumers
Ward 95-4		
	2 RN, 1 PPN, 3	24 consumers

DAY SHIFT (MARCH 3, 2005)

Building 95

Ward 95-1

1 RN, 1 PPN, 4 FMHT — 25 consumers

Ward 95-4

1 RN, 1 PPN, 5 FMHT — 24 consumers

Each staff member receives orientation and training specific to the assigned position within the facility. Direct care staff is involved in a cross-training program regarding care of both the forensic and the civilly committed consumers so that staff can be deployed as needed. This training includes on-going review of knowledge and skills by the immediate supervisor. Staff must be able to demonstrate competency in the key tasks they are expected to perform. Competency is verified either through written tests or "hands-on" demonstration.

6. There are mechanisms for direct care staff and clinical staff to participate in decision-making and planning activities.

Administrative staff described serving on committees and quality improvement teams as two avenues by which staff is able to participate in decision-making and planning activities. Plans are being established to expand these opportunities. The recent participation of staff in discussions related to the revamped staff recognition program was cited as an example of active staff involvement. Direct care staff can share their ideas about consumer care through the supervisory process, at unit meetings and in treatment planning sessions.

Ten of the 16 direct care staff interviewed reported few or no opportunities for staff to actively participate in decision-making and planning activities at the facility. In contrast, all 7 clinical staff who were interviewed stated that they are actively involved in the development of programs and services.

OIG staff was informed that the Facility Director and the Director of Nursing toured the units shortly after the Facility Director's appointment in order to interact with staff and to hear their concerns and frustrations. The majority of direct care staff interviewed (11/16) reported having very little contact with either the facility director or other members of the leadership team.

7. Facility leadership has a plan for creating an environment of care that values employees and assures that treatment of consumers is consistent with organizational values.

Administrative staff reported that the leadership team recently became aware of the need to create a more visible and active staff recognition program as one way of addressing low staff morale. As a result, the facility director created a Staff Appreciation and Awards Committee in January 2005 that is comprised of representatives from a variety of

services. The kick-off activity was the "STAR" (Steps Toward Achieving Rehabilitation) contest that provided an opportunity for all staff to share ideas regarding how the facility could express appreciation and applaud the performance of staff who help consumers reach their highest potential. The results of the contest have not yet been announced at the time of the OIG visit.

Over a third of the 21 staff members who were interviewed reported that they do not feel valued by the facility. Explanations included concerns about overtime and denial of requests to take earned vacation. Those interviewed stated that they work diligently to treat the consumers with dignity and respect and believe that staff deserves the same treatment from the leadership of the facility. The OIG has received five complaints from CSH staff during the past six months. These involved concerns regarding supervisory fairness, excessive overtime and denial of requests for vacations.

OIG staff met with facility leadership to understand their plan for addressing the concerns of nursing staff. The Facility Director and Director of Nursing reported that the nursing department had undergone a reorganization in November 2004 to enhance supervision so that service provision would be more consistent across all 3 shifts. Problems occurred with the implementation of the plan in December when contracts for 12 contract nurses were not renewed and replacement personnel were not hired. Nurses that were promoted to supervisory positions during the reorganization effort in November were asked to once again function as duty nurses due to the shortage. This delayed the reorganization effort that still had not been reinitiated at the time of the inspection. A number of the nurses who were interviewed stated that they felt confused and disillusioned by the reversal and wanted to be allowed to function in their new capacity. They voiced frustration for having to deal with the consequences of events that they believed could have been avoided if there had been adequate advance planning and communication to staff within the facility. The Director of Nursing informed the OIG that a series of meetings with staff has been planned to outline strategies for improving communications, increasing consistency across shifts and providing more flexible scheduling to accommodate staff requests for time-off as long as the requests do not jeopardize consumer and staff safety.

Access

1. There are systems in place to assure that those admitted to the facility are appropriate.

CSH became an active participant in a regional acute care diversion project in 1999. Since that time, civilly committed consumers with acute treatment needs are diverted to private psychiatric care for up to 28 days. A Regional Admissions Committee (RAC), comprised of facility and community staff, manages utilization of both the private beds and the CSH beds. This diversion service enables the facility to serve the more intermediate and longer-term care consumers in the 100 civil beds. The facility admits persons whose mental status and accompanying behavior continues to pose a significant threat of harm to self or to others after they have received acute care in local hospitals.

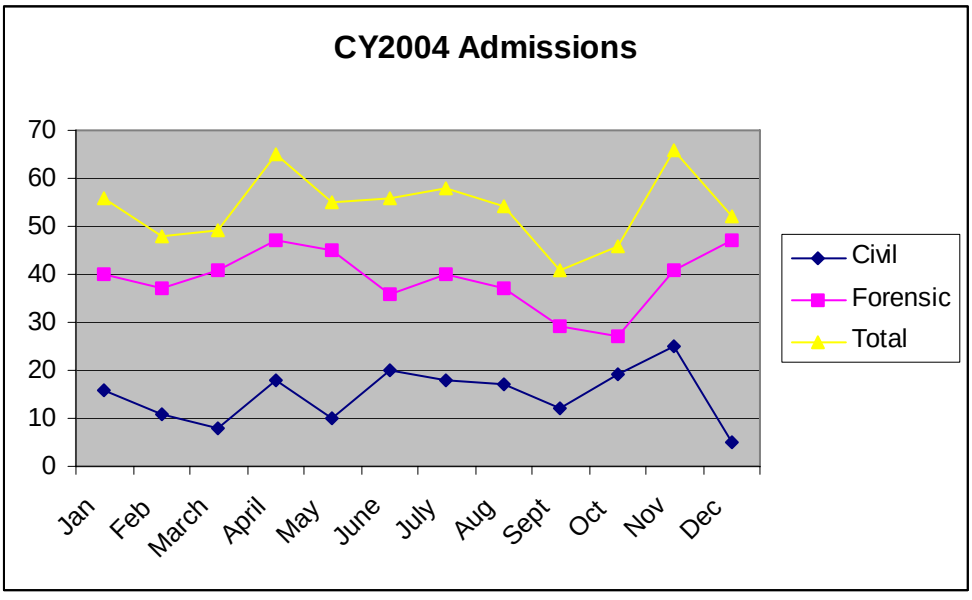
Also, admission to CSH occurs when there are no community-based alternatives available to provide the level of safety and care required as determined by a prescreener from the appropriate CSB. All admissions are prescreened by the CSB as required by the Virginia Code.

CSH also provides forensic services for those persons who need a maximum-security treatment setting. Admission to this service is based on an order from the court and can come from all 40 CSB catchment areas. Clinical staff reported that there is very little involvement of the CSB's in the admission process to forensic services, except when there are emergency transfers from jails for treatment. The facility forensic admission coordinator assures that the appropriate court orders are received and that the requirements for evaluation and/or treatment are consistent with the Virginia Code.

The facility reported the following three primary reasons for denial of admission:

- A request for direct admission to CSH is made when diversion to a local acute inpatient unit is more appropriate. This is the most common reason for denial of admission.
- The facility receives an order for a pre-trial evaluation that could be completed on an outpatient basis. In these situations, CSH makes arrangements for this to occur.
- There is a request for a criminal TDO for a detainee who is a behavior problem and not mentally ill or is mentally ill but not a behavioral problem. In these situations, facility staff discusses alternative ways of managing the case with either the local jail or the CSB prescreener.

There were 646 admissions to the facility during calendar year 2004, which included 179 (27.7%) civil and 467 (72.3%) forensic admissions. Of the total, 470 were male and 177 were female. The admissions per month during calendar year 2004 were as follows:



2. The facility works collaboratively with CSB's to assure access to appropriate services when admissions to the facility are inappropriate or not possible due to census.

Civil admissions to this facility occur when approved by the RAC, and forensic admissions occur when court ordered. As noted previously, the facility works cooperatively with the referral source to assure that the person receives services in the most appropriate setting.

Service Provision

1. There are systems in place to assure that the consumer receives those services that are linked to his/her treatment needs and identified barriers to discharge.

Service provision at CSH includes the integration of medications, psychosocial rehabilitation programming, behavioral treatment and individual treatment. Clinical staff with whom the OIG team spoke stated that the intent of treatment at CSH is to help with symptom control and the development of functional living skills necessary for the consumer to successfully reside in the community.

Each person admitted to the facility undergoes a series of assessments by a number of disciplines. A nursing screening of both medical and psychiatric risk factors occurs within the first half-hour of the admission process. A complete physical examination and psychiatric evaluation are completed within the first 24-hours. The majority of assessments are to be conducted prior to the formal treatment planning session, which occurs within seven days of admission. These assessments become the basis for developing the individualized treatment plan. Interviews with clinical staff indicated that treatment objectives are prioritized with a focus on those objectives that are related to "barriers" to the person re-entering the community. Consumers are active participants in identifying their treatment goals during the treatment planning process. This includes the opportunity to make personal choices regarding participation in the active treatment program.

The OIG reviewed 6 consumer records. Each of the records contained an individualized treatment plan. There was evidence that the plan was based on the assessments completed at the time of admission. A problem list was present in the record, including a listing of the behaviors that were identified as the barriers to discharge. Goals and objectives with corresponding treatment strategies were noted.

CSH operates several psychosocial rehabilitation (PSR) treatment malls that are designed to provide didactic and experiential opportunities for consumers. Groups are offered Monday through Friday, with recreational activities available during the evenings and on weekends.

During the course of the inspection, the OIG observed psychosocial rehabilitation groups in both civil and forensic service treatment malls. A total of 12 groups were observed. Prior to each group, the OIG observer was informed of the general purpose of the group. Overall participation by the consumers in a number of the groups was very limited. In over half of the groups a considerable number of the consumers were sleeping. Several of the group facilitators were not able to successfully engage members in the group experience. OIG staff observed that consumers appeared to be at loose ends during the break periods that were quite long. Several consumers were sleeping in the hall. When asked about this, facility staff reported that the length of the break time was being evaluated to determine if adjustment is needed. Overall, the program offerings occurred on time and as scheduled except for the earliest groups in Building 112, which were delayed because of transportation issues with consumers from Building 94-4 and 95-4. Mall staff reported that there had been transportation difficulties from these units for approximately a week. Following descriptions provide more detail about the observations by OIG staff:

Building 114:

- One group that was scheduled to begin at 10:15 a.m. did not start until 10:30 a.m. because the facilitator was reluctant to begin the group without all of the participants present. Four of the 6 consumers scheduled for the group arrived on time but during the 15-minute delay, 2 consumers who had arrived on time decided to leave and take a "zero" because the room was too cold. The facilitator started at 10:30 with the 2 remaining consumers who then left the room for a bathroom break. At 10:45 the last 2 members of the group arrived.

- The primary activity in another group, which was composed of 5 consumers, was the viewing of a film on how the mind works. When the film began exploring the concept of subliminal messages, the facilitator ended its showing and explained that the film was not as expected. It was obvious from the demeanor of the consumers that the film held very little interest for them. From the comments of the facilitator, it appeared that the film had not been previewed in advance.

- Another group that was observed was reportedly designed to focus on "obtaining treatment team objectives through using and teaching practical skills, and through informal interaction with staff to enhance soft skills such as socialization". The OIG was informed that the staff member who had designed the group had not been available for the past two months. As a result, the testing to identify the skills each consumer is to work on was never completed. Consumers in the group were involved in an activity that had little to do with the program curriculum. Staff was not able to identify individual consumer goals for the activity.

Building 96

- One of the groups observed was late getting started because the facilitator, who was a substitute, had been notified of the need to fill in only moments before the starting time. The group was delayed further because the facilitator realized that

the room was too small to accommodate the 8 consumers assigned to the group. Once the room was rearranged the facilitator was able to engage the consumers.

- Another group, which had 6 consumers, was held in the TV area of the common room. The large space and numerous distractions in the area made it difficult to hear and to attend to the activity. Three of the six consumers appeared to be asleep during the majority of the session.

2. There are processes in place that support evidence-based practices.

According to administrative and clinical staff interviewed, CSH has a number of processes in place that support evidence based practices. The medical staff monitors medication adherence and effectiveness. Unit psychiatrists provide the consumers and/or their LAR with the necessary information to make an informed decision regarding medication usage. Other medication monitors and outcome measures are established such as PRN usage and the use of polypharmacy. Ten of the 13 consumers interviewed reported being fully informed regarding their medications. The other 3 stated they had been given information regarding their medications but had not received information about risks and side effects until they requested it.

Administrative staff reported that other evidence-based practices include the use of seclusion and restraint, psychosocial rehabilitation programming, cognitive-behavioral approaches and national patient safety standards.

3. The facility assures that service provision is grounded in the principles of recovery, self-determination and empowerment.

All 16 of the direct care staff that were interviewed reported having little or no knowledge of the principles of the recovery model. Administrative staff reported that the facility is working on the development of a recovery model curriculum for staff training. It was also reported that one of the hallmarks of the psychosocial rehabilitation program is the active participation of consumers in identifying those courses that will help them address their individualized goals. Nursing management reported recent efforts to help direct care staff listen closely to the concerns of the consumers while assisting them in defining goals and strategies and working toward accomplishing these on a daily basis.

4. There are systems in place to measure the perceptions of consumers, families, direct care staff, clinical staff and administrative staff regarding the quality of the provision of care and services.

The OIG team was informed that the facility conducted consumer satisfaction surveys during March and October 2004. The survey conducted in March focused on satisfaction in areas such as the environment, treatment participation and staff interactions. In response to the March survey, of those who responded, 59% indicated that they felt better as a result of treatment, 23% indicated that they had improved somewhat, and 18% reported no improvement. The October survey contained questions that applied primarily

to the consumers understanding of their rights within the setting. Consumers were again asked about the impact of treatment. This time 63% said they felt better, 26% indicated that they did not know, and 10% reported that they did not feel better.

The facility completed a staff satisfaction survey in December 2004. The results of the survey had not been compiled at the time of the inspection. The survey was designed to measure staff's perceptions in areas such as morale, training, supervision and the general work environment. Administrative staff also reported that staff are able to share their concerns and ideas in supervision, at team meetings and through direct access to the facility leadership team.

The facility does not conduct family satisfaction surveys but indicated that families have opportunities to express their concerns and issues through the complaint process, in treatment team meetings, during visitations and in routine contact with social workers.

Discharge

1. There are systems in place for effective utilization review and management.

CSH has a separate utilization review (UR) and utilization management processes for civilly committed and forensic patients. For the civil beds, these occur within the context of the Regional Admissions Committee (RAC) that is referenced above. The court system provides the framework for these functions for those receiving forensic services. The Not Guilty by Reason of Insanity (NGRI) acquitees are involved in the gradual release process that is comprised of ongoing evaluations and reviews by the Forensic Review Panel.

The facility has a UR manager who monitors the status of the consumers who are admitted to the facility for intermediate or more intensive services. This individual works closely with treatment teams and the RAC to assure that discharges from the facility occur in a timely manner.

2. There are systems in place to assure that effective communication occurs between the consumer, facility and community liaisons regarding discharge readiness in order to assure a smooth transition of the patient into the community and to prevent re-hospitalization.

The facility social worker works with the consumer, the LAR and community services staff to develop a comprehensive list of the services needed by the consumer following discharge. It is the responsibility of the community liaison to develop a plan that will enable the consumer to access these services. Interviews revealed that weekly contact occurs among the consumer, the social worker and the community liaison in order to discuss the status of the plan and to review discharge readiness. Family members (as appropriate), LAR, and community liaisons are invited to participate in the regularly scheduled treatment planning meetings during which discharge readiness and plans are explored. Contact among the parties increases as the time for discharge grows closer.

Crisis plans are developed for those persons who are at high risk of re-hospitalization. These plans are developed with the involvement of the consumer to determine strategies for securing supportive services within the community in the event of a situation that challenges the person's ability to remain safely in the community.

Consumers who are determined to be ready for discharge and remain on the discharge ready list for 30 days are referred to a regional committee that reviews the case and identifies any extraordinary barriers to discharge. This committee has responsibility for developing strategies to address the barriers.

Environment of Care

1. The physical environment is suitable to meet the individualized residential and treatment needs of the patients and is well maintained.

During the three-day inspection, the OIG toured all of the residential units and treatment malls on campus. Overall these areas were clean and well maintained. The units were neat and adequately furnished. Curtains were provided for both privacy and decoration. Efforts to make this very institutional setting appear more homelike were noted in each of the buildings that were toured. Examples include the use of decorative stenciling, faux plants, and pictures.

Buildings 94 and 95 are the residential facilities for the civilly committed consumers. Each building has two wards with separate wings for men and women. The common areas in these buildings are very large which enables greater flexibility in the use of the space. One section in each common room is arranged like a living room with an entertainment unit. Another area is outfitted with dining/game tables. Smaller arrangements of furniture are placed around the perimeter of the common rooms to allow for both private areas and small group interactions. The ceilings are high, with windows that provide natural light. There are payphones for consumer use in each of the common areas.

Buildings 39 and 96 are secured forensic buildings, with 39 serving as the maximum-security unit. In order to enter the buildings, visitors are required to pass through security checkpoints. These buildings have limited decorations for security reasons. All doors to the residential areas and bathrooms are kept locked at all times and monitors are placed outside of bathrooms and throughout the day area in order to enhance security and protection. Each of the wards has a "privilege room" that provides a computer, television and video game equipment. Consumers are allowed to use this room with the approval of a doctor. Unlike the civilly committed consumers, forensic patients do not have smoking privileges.

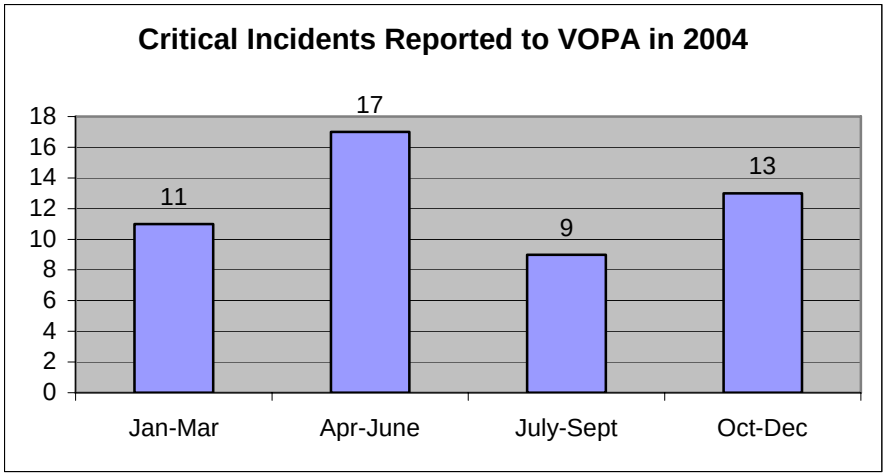
2. There are systems in place to assure that the environment of care is safe and that consumers are protected.

Administrators reported that safety of consumers and staff is one of the highest priorities of the facility. Safety is promoted through environmental checks, staff training, and several reporting systems that enable staff to monitor serious incidents, formal and informal complaints, and allegations of abuse and neglect. All of the staff interviewed reported feeling safe within the facility. A majority of the consumers interviewed also reported feeling safe. The two consumers that reported safety concerns stated that aggressive acts between other consumers in building 39 resulted in their feeling tense and uncertain regarding their own personal safety.

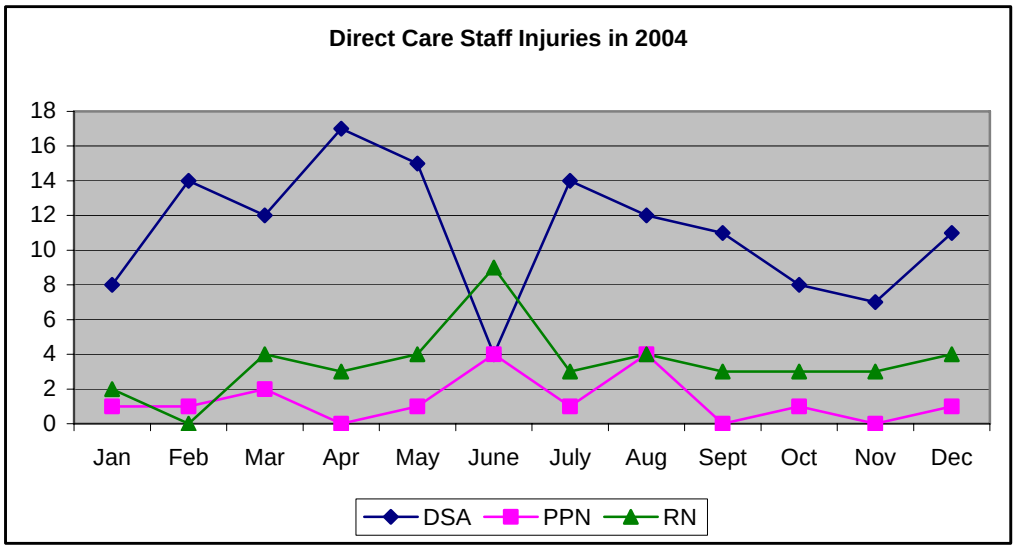
All non-clinical support services for CSH are provided by Southside Virginia Training Center, located on the same campus. Building maintenance and safety checks are the joint responsibility of the Buildings and Grounds and Campus Security departments. Routine safety checks of all buildings are conducted to assure that all equipment is in good working order and potentially hazardous situations are resolved. Staff is expected to report any safety concerns immediately. Work orders are prioritized based on the level of risk involved, with potential life, health and safety code violations attended to first. The facility has a very active Environment of Care Committee that monitors all aspects of safety within the setting.

Staff receives training in key areas that have a direct impact on consumer safety. Examples include fire safety procedures, the management of challenging and difficult consumers, medication risks and benefits, human rights and the reporting of allegations of abuse and neglect. The facility has a risk management program that identifies, evaluates and seeks to reduce the risks associated with injuries, property loss and other areas of liability. Data related to several safety indicators is collected and monitored. This includes patient injuries, patient related staff injuries, allegations of abuse and neglect, formal and informal complaints, and incidents of seclusion and restraint usage.

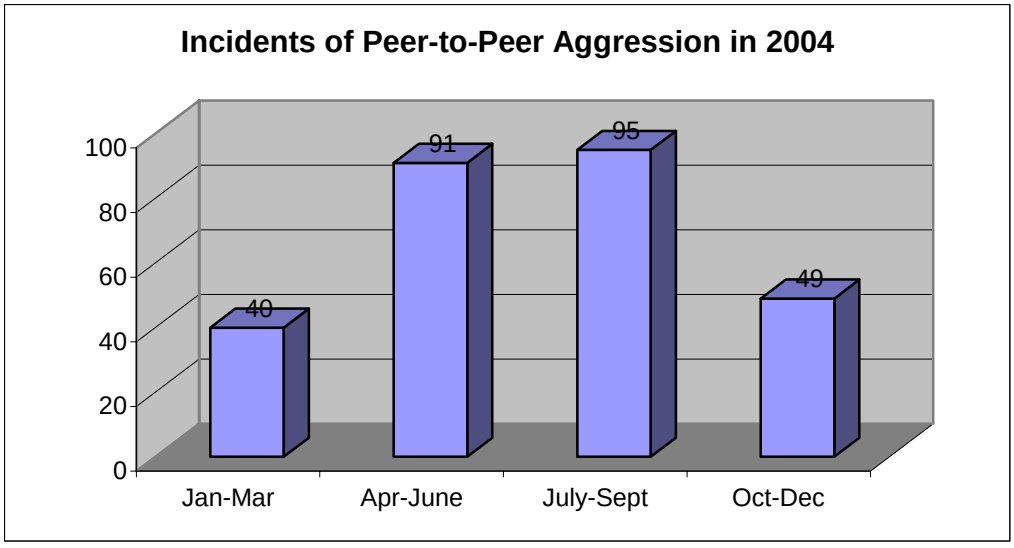
According to information provided by the facility, there were 50 critical incidents at the facility in 2004. The following graph shows the number of reportable incidents per quarter in 2004.



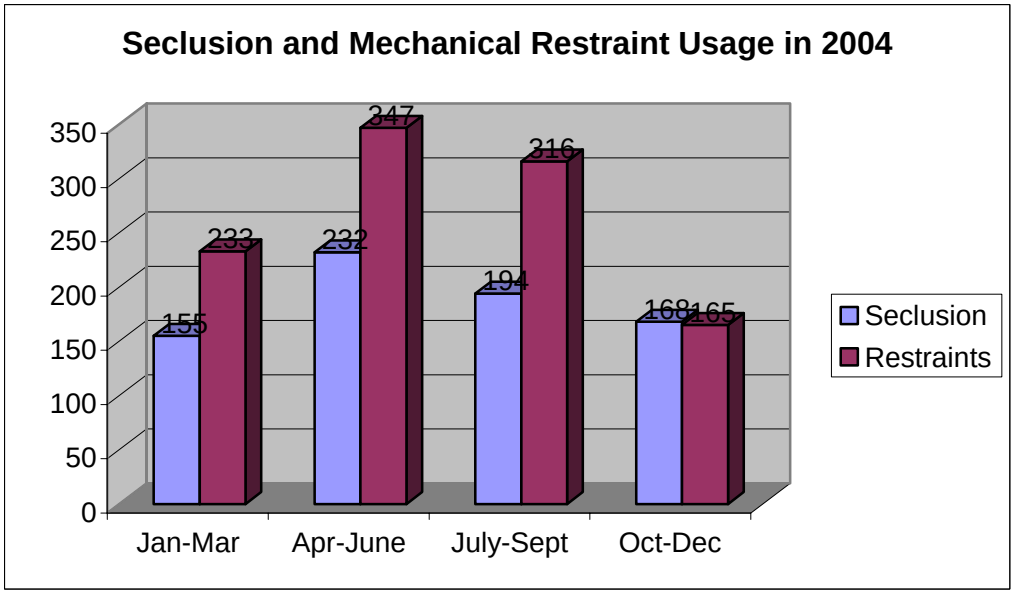
Information from the facility indicated that there were 221 staff injuries during 2004, of which 148 were related to patient care. Monthly data forwarded to the OIG from the facility recorded staff injuries for the following classifications of employees: direct care associates, psychiatric practical nurses and registered nurses. The following graph shows the number of incidents for each classification per quarter during 2004.



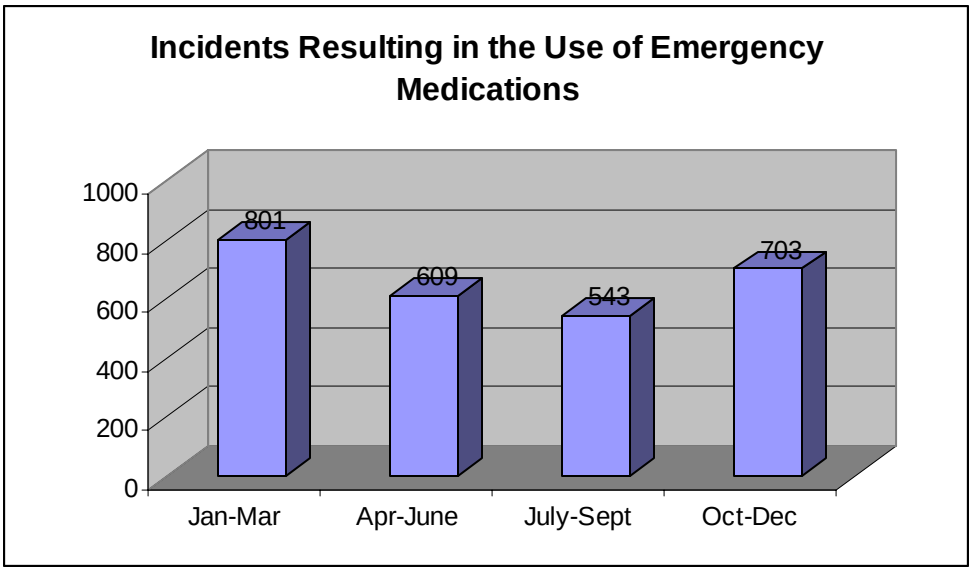
The facility recorded 275 incidents of peer-to-peer aggression during calendar year 2004. Twenty-four of these incidents resulted in an injury to one or both of the consumers involved.



There were 749 episodes that resulted in the use of seclusion and 1,061 episodes that resulted in the use of mechanical restraints during 2004. The facility did not report mechanical restraint usage that was associated with transporting consumers to appointments.



The facility reported that there were 2,656 incidents that resulted in the use of emergency medications during the 2004 calendar year. Incidents per quarter were as follows:



All staff receives training regarding human rights and the reporting of abuse and neglect. There were 119 allegations of abuse and neglect reported in 2004. Of these, 11 were substantiated. Consumers filed 22 informal complaints and 193 formal complaints during 2004.

Quality and Accountability

1. There are systems in place to assure that the services provided from the time of admission to discharge are quality services.

CSH's quality management program has the following primary goals:

1. To enhance the system effectiveness, patient outcomes and patient safety
2. To identify opportunities for improvement through measurable assessment and to ensure sustained performance through on-going monitoring, evaluation, and process improvement
3. To ensure that quality management principles are incorporated into CSH's organizational culture

The facility monitors indicators of quality such as the use of seclusion and restraint, incidents of patient aggression, adverse drug reactions, staff turnover, the use of overtime, and consumer and family complaints.

Clinical staff who were interviewed stated that the quality of care is enhanced by completing thorough clinical assessments, making an accurate diagnosis, developing effective treatment plans, attending to adverse events, engaging the consumers in the treatment process, and facilitating a timely and well planned discharge. Administrative staff noted that quality care is best achieved in an environment that fosters learning opportunities among the staff with prevention, not punishment, being the primary goal.

2. The facility has an accurate understanding of all of the stakeholders' perceptions regarding the services provided by the facility.

Satisfaction surveys are one of the tools used by the facility to gage the perceptions of the various stakeholders regarding the services provided by the facility. A patient satisfaction survey was conducted in March 2004 with a follow-up survey completed in October 2004. The facility also conducted an employee satisfaction survey in December 2004. On-going interactions with community providers and representatives from the CSBs allow or open dialogue regarding services and working relationships.

Recommendations:

The OIG has the following recommendation regarding Central State Hospital as a result of this inspection. Based on the inspections of all 9 mental health hospitals and mental health institutes, a systemic review report will be issued in the near future that includes additional recommendations for all mental health facilities.

Finding #1: In much of the hospital the general morale of direct care staff was quite low. A significant number of those who were interviewed stated that they do not feel valued by the facility, especially the administration. The majority of the direct care staff who were interviewed stated that they have few or no opportunities to actively participate in decision-making and planning activities. Staff throughout the hospital stated that they have very little or no contact with the senior administrators of the facility. The low morale of nurses (RN's) is recognized to be a problem campus-wide and was mentioned as a major concern by all groups of employees including physicians, clinical staff, non-supervisory staff and administrators. Problems with recruitment and retention of direct care staff, especially nurses, places significant pressure on staff to work overtime and limits the use of earned vacation time. Over the past six months, the OIG has received 5 complaints from CSH staff. These involved concerns regarding supervisory fairness, excessive overtime and denial of requests for vacation.

Finding #2: An overwhelming majority of the staff that was interviewed could not provide a clear and consistent description of the facility's mission or the organizational values that have been established to guide how consumers and employees are to be treated.

> **Recommendation for Findings #1 and #2:** It is recommended that the Commissioner of Mental Health, Mental Retardation & Substance Abuse Services appoint an Advisory Committee to the director of CSH. The purpose of this committee will be to assist the director in developing, implementing and monitoring progress toward strategies that will:
>
> - Resolve the longstanding staff morale problems at the facility.
> - Create a common culture throughout the facility in which all staff fully understand their mission and are guided by a common set of values regarding how consumers and staff will be treated

It is suggested that the Advisory Committee be composed of one senior administrator from DMHMRSAS, two directors of state operated mental health or mental retardation facilities, and two other individuals or consultants who are not employed by DMHMRSAS.

DMHMRSAS Response to Finding 1: The Department's Assistant Commissioner for Facility Management, in collaboration with CSH's Facility Director, will name an Advisory Committee to identify strategies aimed at resolving staff morale issues by mid-July 2005. The Advisory Committee will be comprised of representation by two other Facility Directors, a Department senior administrator, as well as consultants identified by the Department's Office of Human Resource and Development. These consultants will be deemed specialists in the field of employee relations. The objectives of this Committee will be: to establish baseline measures to determine the success of morale building initiatives; to develop and provide technical assistance in the implementation of new initiatives and to evaluate existing and new initiatives. In addition, this Committee will monitor on-going and future efforts such as, but not limited to:

- *The Staff Awards and Appreciation Program;*
- *Activities of the newly expanded Leadership Team;*
- *Re-design and implementation of the Employee Forums;*
- *Scheduled Executive Walk-Rounds by members of the Leadership Team as well as more frequent Employee Work Recognition by the CSH Facility Director, the Director of Nursing, and the Director of Forensic Services;*
- *Staff recruitment and retention efforts;*
- *Monthly review of overtime use and denials of scheduled vacation time due to coverage needs; and*
- *Analysis of feedback from surveys of all separating employees.*

[Detailed descriptions of current CSH activities cited above are available upon request.]

DMHMRSAS Response to Finding 2: CSH is updating its mission, values and philosophy to more accurately reflect those of the DMHMRSAS. Staff at all levels of the facility will be involved in this effort. We are in agreement with the OIG that this work is critical to assuring that employees are on board with a common set of values reflecting how staff is treated by administration, how they treat one another and how they treat consumers. The target completion date is October 15, 2005 for the completion of the vision, mission and values. Combined staff forums will also be undertaken to provide discussion and ideas assuring continual feedback and identification of opportunities to feed the positive culture in the facility environment. In collaboration with the Advisory Committee, pre- and post measures will also be developed to establish a baseline to monitor progress in the understanding of these principles. Outcome measures will be provided to the OIG as requested and further training and forums will be provided as indicated.

Finding #3: Consumer engagement and participation in the psychosocial rehabilitation program (PSR) was very limited. In over half of the groups that were observed, a considerable number of the consumers were sleeping. In several groups the consumers did not arrive for their classes on time and left before the group session was over. In some groups the content was not presented at a level that could be understood by consumers. Several facilitators were not adequately prepared to conduct the session.

> **Recommendation:** It is recommended that the facility establish a committee composed of clinical, rehabilitation, and medical staff as well as consumers, with representation from the senior facility administrative staff to:
>
> - Review and evaluate each PSR course offering to determine the appropriateness of the content for consumers and make recommendations for retention, redesign or elimination as appropriate.
> - Recommend any additional offerings that are needed.
> - Recommend a system for selecting and preparing staff to teach or facilitate each PSR offering.
> - Recommend an ongoing system for monitoring the effectiveness of individual facilitators and the effectiveness of the content so that changes can be made as needed.
>
> Once the recommendations have been formulated, the facility director should assure implementation.

DMHMRSAS Response: CSH has established a PSR Program Steering Committee that includes the following members: the Acting Director of Staff Development and Training, the Medical Director, and the Directors of Rehabilitation Services, Nursing, Psychology, and Social Work. In addition, at least one consumer will be added to this Committee. The Steering Committee, in collaboration with the treatment teams, has begun a full evaluation of the current PSR program. Using a standardized assessment tool, each treatment team, which includes the patient, is identifying the current needs of each consumer. This assessment is to be completed by the treatment teams no later than July 15th, 2005, and results will be forwarded to the full Steering Committee. The Steering Committee will analyze the data and make recommendations for the retention, re-design, elimination or addition of program offerings. Each offering is expected to support the principles and values of recovery. Offerings will be individualized, person-centered, and skill acquisition based; focus on discharge needs and relapse prevention; and be "real world" focused. The Committee will complete its recommendations by the end of October 2005.

The Steering Committee will initiate targeted workgroups that will conduct a review of current processes for: selecting, training, and evaluating group facilitators; preparing staff who provide back-up for each group when absences occur; developing and monitoring group content; and improving feedback between patient, facilitator and treatment team on patient progress. The work groups will include representatives from clinical and direct care staff and senior administrative staff. Using the findings from those reviews, the full Steering Committee will develop and implement improvements, as indicated, to maximize the effectiveness of each PSR group; and will develop and

implement monitoring processes to ensure consistency over time. The Steering Committee will also evaluate current processes for evaluating and monitoring patient progress in each group so that changes in content or group can be made in a timely manner. These activities will be completed by December 2005.

The Steering Committee will provide monthly progress reports to the Facility Director throughout these activities, and these reports will be forwarded to the Assistant Commissioner of Facility Management and to the OIG if requested.

I would like to formally notify you of an important initiative that is relevant to your report. The DMHMRSAS Human Resource (HR) Special Emphasis Steering Committee is engaged in on-going efforts to address employee issues system-wide. The HR Committee workgroups are tasked with developing systemic solutions to five major personnel issues across all facilities considered critical to staff job satisfaction, retention and recruitment at facilities. These Committees include: promoting good attendance; promoting a positive work environment and leadership; professional and career development; improving retention and recruitment; and identifying appropriate relief factors. Many of the issues addressed and ideas forthcoming are anticipated to assist in addressing employee morale concerns and creating a positive work culture. Recommendations from these workgroups may be included in the Department's budget proposal for the next biennia.

In addition, in response to the OIG's findings to date regarding PSR programs in state psychiatric facilities, the Department will initiate an internal workgroup, which will include facility representatives, to undergo a thorough review of all PSR programs.